SUBCOMMITTEE #3:
Health & Human Services

Chair, Senator Mark Leno

Senator Elaine K. Alquist
Senator Roy Ashburn

March 25, 2010

9:30 a.m. *or*
Upon Adjournment of Session
Room 4203
(John L. Burton Hearing Room)

(Diane Van Maren)

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PLEASE NOTE:
Only those items contained in this agenda will be discussed at this hearing. Issues will be discussed in the order as noted in the Agenda unless otherwise directed by the Chair. *Please* see the Senate File for dates and times of subsequent hearings.

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Thank you.

I. Department of Health Care Services—Medi-Cal Program

A. OVERALL BACKGROUND

Purpose: The federal Medicaid Program (called Medi-Cal in California) provides medical benefits to low-income individuals who have no medical insurance or inadequate medical insurance. *Generally*, California receives a 50 percent match from the federal government for most Medi-Cal Program expenditures. *However*, federal American Recovery & Reinvestment Act of 2009 provides an enhanced federal match of 61.59 percent (from October 2008 to December 30, 2010).

Medi-Cal is at least three programs in one: (1) a source of traditional health insurance coverage for low-income children and some of their parents; (2) a payer for a complex set of acute and long-term care services for the frail elderly and people with developmental disabilities and mental illness; and (3) a wrap-around coverage for low-income Medicare recipients ("dual" eligibles who receive Medicare and Medi-Cal services).

Who is Eligible and Summary of Medi-Cal Enrollment: Generally, Medi-Cal eligibles fall into four categories of low-income people as follows: **(1)** aged, blind or disabled; **(2)** low-income families with children; **(3)** children only; and **(4)** pregnant women.

Men and women who are *not* elderly and do not have children or a disability *cannot* qualify for Medi-Cal no matter how low their income. Low-income adults without children must rely on county provided indigent health care, employer-based insurance or out-of pocket expenditures or combinations of these.

Generally, Medi-Cal eligibility is based upon family relationship, family income level, asset limits, age, citizenship, and California residency status. Other eligibility factors can include medical condition (such as pregnancy or medical emergency), share-of-cost payments (i.e., spending down to eligibility), and related factors that are germane to a particular eligibility category. States are required to include certain types of individuals or eligibility groups under their Medicaid state plans and they may include others—at the state's option.

The Medi-Cal Program also has several "special programs" that provide limited services for certain populations**.** These include the **(1)** Emergency Medical Services Program which provides emergency medical services to undocumented individuals; **(2)** the Family PACT Program which provides reproductive health care services; **(3)** the Breast and Cervical Cancer Program which provides services related to cancer for women up to 200 percent of poverty; **(4)** the Disabled Working Program which allows certain disabled working individuals to pay a premium to buy into the Medi-Cal Program; and **(5)** the Tuberculosis Program which provides treatment for TB. These programs are limited in their eligibility and in the services that are funded under them.

Estimated Medi-Cal enrollment for the current year is about 7.3 million people and for 20010-11 it is 7.5 million people. Medi-Cal provides health insurance coverage to about 19 percent of California's population, or almost one in every five people (assumes a population of 38.8 million). Most Medi-Cal clients are from households with incomes at or below 100 percent of poverty ($18,310 for a family of three).

The projected Medi-Cal eligible caseload is summarized in the table below.

Summary of Caseload Medi-Cal Eligibles	20010-11 Estimated Eligibles
Families/Children	
CalWORKS	1,467,600
Working Families (1931 b Program)	3,100,000
Pregnant Women	35,900
Children (100 % and 133% programs)	294,500
Aged/Disabled	
Aged	712,700
Blind	23,300
Disabled	1,128,400
Medically Indigent	232,500
Other Various Categories	461,600
Undocumented Persons	67,600
TOTALS	**7,524,100**

Summary of Proposed Budget—Significant Reductions. The Governor proposes total expenditures of $40.3 billion ($12.9 billion General Fund, $25 billion federal Title XIX Medicaid funds, and $2.4 million in other funds) for local assistance the Medi-Cal Program in 2010-11. This reflects a proposed *decrease* of $8.8 billion (total funds) as compared to the revised 2009-10 budget.

This reflects a *net* General Fund increase of $678.2 million, or an increase of about 5.5 percent above the revised current-year level as shown in the chart below.

Medi-Cal Funding Summary *(Dollars in Thousands)*	2009-10 Revised	2010-11 Proposed	Difference	Percent
Local Assistance				
Benefits	$45,752,600	$37,020,500	-$8,732,100	-19.1
County Administration (Eligibility)	$3,116,100	$3,007,400	-$108,700	-3.5
Fiscal Intermediaries (Claims Processing)	$309,900	$302,600	-$7,200	-2.3
Total Local Assistance	**$49,178,500**	**40,330,500**	**-$8,848,000**	**-18.0**
General Fund	$12,232,900	$12,911,100	$678,200	5.5
Federal Funds	$33,653,300	$25,017,300	-$8,636,000	-25.7
Other Funds	$3,292,500	$2,402,100	-$890,400	-27.0

B. Vote Only Issues (Pages 4 through 5)

1. Delay California Discount Prescription Drug Program (CDPDP)

Budget Issue. The DHCS proposes trailer bill language to delay implementation of this new program until 2011-2012 due to continued fiscal constraints. Further, the DHCS proposes to end the program by February 1, 2012 if funding is not provided in subsequent legislation.

Due to budget conditions in 2007-08 and 2008-09, the Governor vetoed funding for this new program. In 2009-2010 funding was not provided and statute was modified to delay implementation. The Governor's January budget for 2010-11 does not contain an appropriation for this new program either.

Background—AB 2911 (Nunez), Statutes of 2006. This legislation created the CA Drug Discount Prescription Drug Program to address concerns regarding the lack of access to affordable prescription drugs by lower-income Californians. This program is a drug discount program, not a benefit. The general structure of the program is for the state to negotiate with drug manufacturers and pharmacies for rebates and discounts to reduce prescription drug prices for uninsured and underinsured lower-income individuals.

Participation in the program is eligible uninsured California residents with incomes below 300 percent of the federal poverty, individuals at or below the median family income with unreimbursed medical expenses equal to or greater than 10 percent of the family's income, share-of-cost Medi-Cal enrollees, and Medicare Part D enrollees that do not have Medicare coverage for a particular drug.

Subcommittee Staff Comment and Recommendation—Approve. Though implementation of this new program has merit, due to the continued fiscal crisis it is recommended to approve the trailer bill language to delay implementation of this program for 2010-11. Subsequent legislation or budget appropriations could be provided in future years if the design and need for program are warranted.

2. DHCS Staff for Mental Health Supplemental Payments

Budget Issue. The DHCS proposes expenditures of $216,000 ($108,000 Reimbursements from County Mental Health, and $108,000 federal funds) to support two State positions, including a Staff Counsel (three-year limited-term) and an Associate Governmental Program Analyst (permanent) to conduct work regarding the Mental Health Services Supplemental Payment Program authorized in 2009.

The DHCS states the Staff Counsel position will perform legal workload required to establish and implement the program and to ensure it complies with federal law requirements. The other position will administer the actual reimbursement aspects of the program.

Mental Health Supplemental Payments Program to be Included in Amendment. The Budget Act of 2009 established a *new* "Mental Health Services Supplemental Payment Program" to authorize the use of County CPE's for costs of mental health services provided to Medi-Cal clients that exceed their current payment levels. Participation in the program by Counties is voluntary.

The supplemental payment would consist of the difference between the current Fee-for-Service rate being paid for these services and the actual costs to the counties to provide the mental health services. It is anticipated that supplemental federal payments will provide a total of $27.7 million (federal funds) for 2008-09, $55.4 million (federal funds) for 2009-2010, and $27.7 million (federal funds) in 2010-11. There is no General Fund impact to this program.

To-date, no federal funds have been received since the State Plan Amendment needed from implementation is now part of the overall Medi-Cal Mental Health Waiver and audit change package being negotiated with the federal CMS. Hopefully this will be reconciled by August 2010. The DMH and DHCS are to keep the Legislature informed of progress.

Subcommittee Staff Comment and Recommendation—Approve. There is no General Fund impact to this proposal and staff is needed to proceed with this new program. No issues have been raised regarding these positions.

C. ISSUES FOR DISCUSSION

1. Governor's Federal Fund Assumptions for Medi-Cal: Several Components

Budget Issues. There are several components to the Governor's January budget for the receipt of federal funds under Medicaid (Medi-Cal Program). These federal fund assumptions for Medi-Cal, along with several others, are tied to the Governor's "trigger" proposal. (The "trigger" mechanism is discussed separately in issue 2 of this Agenda.)

Each of the federal fund assumptions is described below, and *Table 1* (*Page 11*) provides a summary of the dollars. Receipt of these federal funds saves General Fund support. In some instances as noted, the receipt of new additional federal funds will require the State to identify an appropriate State match in order to draw the funds and offset General Fund support.

- **A. Receipt of federal ARRA funds through December 31, 2010.** The federal ARRA enacted by President Obama in 2009 provided increased federal funding for State's from October 2008 through December 31, 2010 (27 months). California is to receive a 61.59 percent federal medical assistance percentage (FMAP), or 11.59 percent *above* our standard level of 50 percent.

  This enhanced funding reduces General Fund expenditures in a corresponding manner. Certain local fund commitments, such as County Realignment expenditures, are also reduced. No issues are raised with this baseline assumption.

- **B. Assume extension of federal ARRA to June 30, 2011.** The Governor's budget assumes the federal government will pass legislation to extend the ARRA for another 6 months to June 30, 2011. The DHCS budget assumes about $1.5 billion in federal funds for this extension which would be used to offset General Fund support in the Medi-Cal Program and other departments. There have been several proposals for federal extension, most recently the Senate included an extension in H.R. 4213 (American Workers, State and Business Relief Act) on March 10. The Governor's "trigger" calculation assumes a total of $2.1 billion (federal funds) for this extension which includes other federal ARRA funds in addition to these Medicaid (Medi-Cal) funds.

  The LAO is on record for concurring to assume this extension for 2010-11.

- **C. Receipt of unexpended federal funds from Hospital Financing Waiver and federal ARRA 61.59 Percent.** California's existing Hospital Financing Waiver, enacted in 2004 through SB 1100 (Ducheny and Perata), is a key Waiver that provides reimbursement to designated safety net hospitals (about 146 hospitals). It is in effect until August 31, 2010.

This Waiver contains provisions for the receipt of $360 million for expansion of Medi-Cal Managed Care through “mandatory” enrollment of seniors and persons with disabilities. This $360 million (federal funds) was left *unexpended* at the time due to the need for considerable health care system changes prior to such implementation. Through the Budget Act of 2009 (July), it was assumed California would obtain these unexpended federal funds pending discussions with the federal CMS.

The DHCS has reached a tentative agreement with the federal CMS to obtain the unexpended $360 million from the Waiver, *plus an additional* $423.8 million to reflect enhanced federal ARRA funding. This $783.8 million (across two-fiscal years) serves as an offset to General Fund support in the Medi-Cal Program.

There are *two key* aspects to this tentative agreement. First, the DHCS has agreed to meet new milestones, as negotiated with the federal CMS, which focus on serving very medically involved individuals. Three demonstration projects (pilots) have been identified for this purpose, as follows:

1. *Implement Disease Management Projects in Los Angeles and Alameda.* This project specifies that at least 19,000 individuals enrolled in Medi-Cal Fee-for-Service who are seniors and disabled individuals living in these counties are to be in a Disease Management Program by no later than August 31, 2010 (Waiver sunsets).

2. *Implement an End of Life Coordinated Care Management Project.* This project specifies that at least 5,000 individuals enrolled in Medi-Cal Fee-for-Service who are seniors and disabled individuals and seriously ill and/or near the end of life are to receive assistance. This pilot is to focus on Butte, Contra Costa, El Dorado and Placer counties.

3. *Implement a Serious Mental Illness Coordinated Care Project.* This project specifies that at least 5,000 individuals enrolled in Medi-Cal Fee-for-Service who are seniors and disabled individuals who are seriously mentally ill are to receive coordinated case management services.

Second, the $783.8 million (across two-fiscal years) in federal funds require a State match for their receipt. As provided for under the Hospital Financing Waiver, California can use “certified public expenditures” (CPE’s) which include all sources of funds available to *government* entities (public) that directly operate health care. In an effort to mitigate demands on State General Fund, California has been utilizing “CPE” from several State-operate programs, as well as from Public Hospitals (as designated). The use of CPE’s has been ongoing since inception of the Waiver.

However, with the newly identified $783.8 million in available federal funds, additional CPE's to match these federal dollars is needed. The DHCS has been working with the federal CMS, as well as the Public Hospitals and others, to discern an approach to identify the appropriate sources. *No resolution has as yet been reached.*

There are two key issues related to identifying appropriate CPE's for this match. First, the DHCS has identified additional State CPE's that can be used for this purpose. The State Programs identified by the DHCS include the following programs:

- AIDS Drug Assistance Program (ADAP) — newly added
- Mental Health Services Act Funds — newly added
- County Medical Services Program — newly added
- Expanded Access to Primary Care — newly added
- California Children Services Program — ongoing
- Medically Indigent Adults, Long-Term Care — ongoing
- Breast and Cervical Cancer Treatment — ongoing
- Genetically Handicapped Persons Program — ongoing

Generally, for the State to claim CPE's for these programs there needs to be clarity that public funds are being expended for health care services and that these funds are *not* otherwise being used to match other federal funds (cannot use funds to match federal dollars multiple times). The federal CMS requires detailed reporting and conducts audits on these funds to ensure the appropriateness of their use.

With respect to the newly added programs, the DHCS has informed Subcommittee staff that use of the ADAP CPE's poses no issues with the operations of the ADAP. They contend there would be *absolutely no impact* to ADAP with respect to the Ryan White CARE Act Funds or the receipt of ADAP Drug Rebate Funds.

The amount of CPE's to be calculated for the Mental Health Services Act Funds (MHSA Funds) has not yet been provided to Subcommittee staff but preliminary DHCS estimates have referenced from $300 million to $500 million. The DHCS is having discussions regarding this calculation. As discussed in the March 11, 2010, Subcommittee hearing, MHSA Funds are primarily continuously appropriated to local County Mental Health Plans and used for various mental health care purposes. It is likely that some portion of these MHSA Funds can indeed be identified for CPE use.

However, there will be a need to ensure that any CPEs meet federal CMS requirements. This aspect will involve working with the County Mental Health Plans and the Department of Mental Health.

Second, the use of more CPE's from the Public Hospitals also needs to be clarified. Presently, CPE's from the Public Hospitals are used extensively under the Hospital Financing Waiver, including drawing federal funds for the Safety Net Care Pool, as well as for federal Disproportionate Share funding. Generally, Public Hospitals do not receive State General Fund support for Medi-Cal purposes and must access CPE's to obtain the federal match, including for inpatient per diem purposes.

Due to the present structure of the Waiver, particularly the cap on the Safety Net Care Pool Funds, *not* all of the available CPE's are being used to match federal funds. In other words, more public expenditures are being spent for which we are not claiming a federal match through the Waiver. Therefore, a portion of these "available" CPEs can be used to draw the newly available federal funds.

However, a balance of what is reasonable to use to assist in obtaining the $783.8 million in additional federal funds needs to be more fully discussed and clarified. This is a complex issue and could have considerable implications for the new 1115 Medi-Cal Waiver which is presently being crafted. It is reasonable to assume that public entities would want to receive an equitable benefit for expending their funds for the federal match.

Also, any additional CPE's require federal CMS approval as referenced previously and Public Hospitals would be at risk in meeting these requirements.

- **D. Assume increase in base FMAP from 50 percent to 57 percent.** The Governor is seeking federal law changes to the formula used to calculate the federal medical assistance percentage (FMAP) which would increase California's baseline from 50 percent to potentially 57 percent. The 57 percent figure used by the Administration is based on an average of what ten other large states receive. As noted in Table 1 below, the January budget assumes $1.8 billion (federal funds) from this proposal. The Administration would use these funds as an offset for General Fund support. This is part of the Governor's "trigger" calculation.

- **E. Enhanced FMAP for Medicare Part D "clawback".** The Governor's January budget assumes receipt of $250 million (federal funds—one time only) by applying the federal FMAP ARRA to California's payment to the federal government for its Medicare Part D "clawback" (States' cost-sharing requirement to the federal government for this prescription benefit). The Administration would use these funds as an offset for General Fund support. This is part of the Governor's "trigger" calculation.

  In mid-February, federal HHS Secretary Sebeilus announced the federal government would be providing States with fiscal relief by applying federal FMAP ARRA to the "clawback" for October 2008 through December 31, 2010. This action provided California with a total of $680.6 million in one-time federal offsets to California's General Fund. The $680.6 million is $430 million *more* of an offset than contained in the Governor's January budget.

If the federal ARRA is extended to June 30, 2010, an *additional offset* of $166.5 million could be obtained (i.e., 11.59 percent for the six months), for a total of $847.1 million.

- **F. Request to change Medicare Part D "clawback" calculation.** The Governor's January budget assumes federal relief of $75 million (ongoing) by making changes to the federal government's formula for calculating the clawback. This requires federal law changes. The Administration would use these funds as an offset for General Fund support. This is part of the Governor's "trigger" calculation.

- **G. Reimbursement to California for Medicare Disability Determination.** The Budget Act of 2009 (July) assumed receipt of $700 million (federal funds-one time) from the federal government for repayment of funds expended through the Medi-Cal Program which should have been the sole responsibility of the federal Medicare Program. All States are affected by this systemic error on the part of the Social Security Administration. This issue continues to be part of the overall federal funding discussion for States, and would require federal law changes.

  The Administration would use these funds as an offset for General Fund support. This is part of the Governor's "trigger" calculation.

- **H. Federal CMS adjustment to State's Family PACT Waiver—more federal funds.** Effective July 2009, the federal CMS reviewed California's existing adjustment within our Family PACT Waiver for individuals otherwise not eligible for Medi-Cal and determined this adjustment should be lower—from 24 percent to 13.95 percent. The effect of this adjustment is that California will receive increased federal funds of $50.8 million in 2009-10 and $ $58.2 million in 2010-11. These additional federal funds serve as an offset to General Fund support. This receipt of federal funds is not part of the trigger calculation.

(Summary Table 1 of federal funds on next page.)

Table 1—Summary of General Fund Savings from Above Federal Fund Assumptions

California's Medi-Cal Program (Title XIX Funds) Description of Federal Component (Dollars in Thousands)	Governor's Revised 2009-10	Governor's Proposed 2010-11	Total General Fund Savings
1. Receipt of federal ARRA thru December 31, 2010 *	**$3,794,472**	**$1,447,788**	**$5,242,260**
• Total DHCS	($2,879,478)	($1,190,873)	($4,070,351)
• Total Other Departments	($914,994)	($256,915)	($1,171,909)
2. Extension of federal ARRA to June 30, 2011 ***	--	**$1,500,700**	**$1,500,700**
• Total DHCS	--	($1,191,000)	($1,191,000)
• Total Other Departments	--	($309,700)	($309,700)
3. Apply federal ARRA to existing Hospital Waiver ***	**$380,268**	**$43,501**	**$423,769**
4. Receipt of unexpended federal funds Hospital Waiver ***	**$360,000**	--	**$360,000**
5. Assume increase in base FMAP from 50% to 57% ***	--	**$1,819,000**	**$1,819,000**
• Total DHCS		($1,445,000)	($1,445,000)
• Total Other Departments		($374,100)	($374,100)
6. Enhance FMAP for Medicare Part D "Clawback" **		**$250,000**	**$250,000**
7. Request to change Medicare Part D "Clawback" ***		**$75,000**	**$75,000**
8. Reimbursement of Medicare disability determinations***		**$700,000**	**$700,000**
9. Federal CMS adjustment for Family PACT Waiver *	**$50,800**	**$58,200**	**$109,000**
TOTALS	**$4,585,540**	**$5,894,189**	**$10,479,729**

***** Federal dollars confirmed for these items.
****** Federal dollars received are $430.6 million *more than* in Governor's January budget.
******* Discussions are continuing on these items.

Subcommittee Staff Comment and Recommendation. As noted above, the federal funding components for the Medi-Cal Program are complex and have nuances. Due to these aspects, it is important to have transparency for the Legislature to be appraised of both funding and policy concerns. The Legislative Leadership has facilitated receipt of federal funds in several areas already and is poised to continue in this role.

As the State's designated entity, the DHCS has the responsibility to secure, track and monitor these federal funds. It is a complex task and a vital role. The work of the DHCS is appreciated.

it is recommended to have the DHCS provide the Subcommittee with a detailed update on the receipt of these federal funds, as well as more clarity regarding the CPE structure, at the May Revision.

Questions. The Subcommittee has requested the DHCS to respond to the following questions:

1. DHCS, Please discuss and explain each component of the anticipated federal funds for the Medi-Cal Program.
2. DHCS, with respect to the Hospital Financing Waiver, when will we have more clarity regarding the use of CPE's and federal CMS approval?
3. DHCS, Are there any other nuances which the Subcommittee should be appraised of?

2. Governor's Proposed Trigger Mechanism

Budget Issues. The Governor's proposed "trigger" mechanism has two key aspects. First, a sweeping Budget Control Section provides broad authority to the Department of Finance (DOF) to make fiscal reductions if the $6.9 billion federal fund target, as defined by the Governor, is not obtained. Second, a comprehensive trailer bill package provides authority to the DOF to drastically alter the Medi-Cal Program if the trigger is pulled. The Budget Control Section and trigger mechanism are described in more detail below.

This discussion will focus on the Administration's trailer bill package as it pertains to Medi-Cal and its potential consequences for the people of California.

First, the trailer bill package would radically reduce Medi-Cal eligibility for various low-income people, most living below the federal poverty level ($18,310 annually for a family of 3), by imposing the existing federal minimum coverage required of States *prior* to the passage of federal Health Care Reform. Millions of Californians, including children, working families, and aged, blind and disabled individuals would be eliminated from health care coverage under the Governor's scenario. People would need to seek episodic care through emergency rooms, clinics and county indigent health facilities.

Second, the trailer bill package would provide DOF authority to eliminate certain benefits, which under federal law, are considered "optional" for States to provide to adults. Table 1 below provides a summary of the DHCS' estimate of the proposed trigger on the Medi-Cal Program.

Table 1: Summary of DHCS Estimate of Trigger Impact to Medi-Cal

Description of Proposal	Persons Impacted *Fully* Implemented	General Fund Reduction for 2010-11
A. Medi-Cal Eligibility Reduction (assumes 1/01/2011):		
1. Rollback 1931 (b) to minimum	-433,582	-$27,375,000
2. Rollback Aged, Blind, & Disabled	-93,396	-$52,287,000
3. Eliminate Medically Needy Program	-42,809	-$290,888,000
4. Eliminate Children's Gateway Pre-enrollment	-676,216 screens	-$8,120,000
5. Eliminate Accelerated Children's Single Point of Entry	-35,925	-$1,461,000
6. Eliminate Medi-Cal Expansion—Former Foster Care	-4,776	-$1,559,000
7. Eliminate Breast & Cervical Cancer Treatment	-9,269	-$20,383,000
8. Eliminate Medically Indigent Adult Long-Term Care	-943	-$11,115,000
9. Eliminate Family PACT Program	-1,600,000	-$64,133,000
TOTAL Proposed Eligibility Reduction	**-2,220,790**	**-$477,321,000**
B. Medi-Cal Benefit Reduction (assumes 6/01/2010)		
1. Eliminate Adult Optional Benefit: Hearing Aids		-$2,691,000
2. Eliminate Adult Optional Benefit: Physical Therapy		-$40,000
3. Eliminate Adult Optional Benefit: Occupational Therapy		-$4,000
4. Eliminate Adult Optional Benefit: Orthotics		-$30,000
5. Eliminate Adult Optional Benefit: Indep Rehab Facilities		-$4,000
6. Eliminate Adult Optional Benefit: Outpatient Heroin Detox		-$61,000
7. Eliminate Adult Optional Benefit: Medical Supplies		-$19,204,000
8. Eliminate Adult Optional Benefit: Prosthetics		-$570,000
9. Eliminate Adult Optional Benefit: Durable Medical Equip		-$24,669,000
TOTAL Proposed Optional Benefit Reduction	**over 223,000**	**-$47,273,000**
TOTAL Proposed Reductions	**-2,220,790**	**-$524,594,000**

The DHCS eligibility figures assume that children who are dropped from 1931 (b) eligibility are redetermined to be eligible for the 100 percent or 133 percent of poverty categories of Medi-Cal. In practice, it is very likely that many children would actually lose coverage since families would need to have their children re-determined which creates a hurdle for continued enrollment.

The Governor's trigger identifies nine "Optional" benefits in Medi-Cal which would be eliminated. The DHCS reduction amounts assume that some expenditure would be shifted to other Medi-Cal services. The Table below displays the DHCS assumptions regarding potential cost shifts to other Medi-Cal provided mandatory services. For example, if hearing aids are eliminated no other Medi-Cal service is available for treatment/assistance. With respect to outpatient heroin detoxification, it is likely that inpatient services would become necessary but this cost is not captured in the assumptions.

DHCS Medi-Cal Optional Benefits-- Trigger	**DHCS Assumption**
1. Eliminate Adult Optional Benefit: Hearing Aids	Assumes no cost shift
2. Eliminate Adult Optional Benefit: Physical Therapy	90 percent shift to mandatory service
3. Eliminate Adult Optional Benefit: Occupational Therapy	60 percent shift to mandatory service
4. Eliminate Adult Optional Benefit: Orthotics	75percent shift to mandatory service
5. Eliminate Adult Optional Benefit: Indep Rehab Facilities	60 percent shift to mandatory service
6. Eliminate Adult Optional Benefit: Outpatient Heroin Detox	Assumes no cost shift
7. Eliminate Adult Optional Benefit: Medical Supplies	30 percent shift to mandatory service
8. Eliminate Adult Optional Benefit: Prosthetics	75 percent shift to mandatory service
9. Eliminate Adult Optional Benefit: Durable Medical Equip	25percent shift to mandatory service

Some of the above categories are quite broad as to what is covered, particularly "Medical Supplies" and "Durable Medical Equipment". The Medical Supplies category includes diabetic supplies, all wound care, infusion supplies, tracheotomy care, and many others. Durable Medical Equipment includes wheelchairs and accessories, oxygen and respiratory equipment, ostomy pouches, and many others.

it should be noted that the Budget Act of 2009 (July) did eliminate ten Optional benefits for adults (not in nursing homes or pregnant), including Adult Dental, acupuncture services, chiropractic services, incontinence creams and washes, optician/optical lab services, optometry services, podiatry services, psychology services, speech therapy and audiology services.

Background-- Budget Control Section 8.26 (Budget Bill, page 646). This control section provides **(1)** broad authority to the Director of Finance to determine by July 15, 2010, if the State has received $6.9 billion in additional federal funds which can be used in lieu of General Fund support for 2010-11; and **(2)** enables the Director of Finance to *adjust appropriations as necessary* in accordance with statute.

Background--Description of Governor's "Trigger" Mechanism. The Governor proposes *overall* reductions of $4.6 billion (General Fund) and revenue adjustments of $2.4 billion (General Fund) in the event the federal government does not provide $6.9 billion in additional federal funding. The Table 2 below provides a listing of the Governor's federal requests which are counted towards this trigger mechanism.

Table 2: List of Governor's Federal Requests Associated with "Trigger" Proposal

Governor's Federal Request	2010-11 Budget Assumption
1. Extend federal ARRA to June 30, 2010 (all health & human srvs)	$2.1 billion
2. Increase FMAP from 50 percent to 57 percent	$1.8 billion
3. Obtain federal ARRA FMAP for Medicare Part D Clawback	$250 million
4. Change Medicare Part D Clawback calculation	$75 million
5. Reimbursement for Medicare Disability Redetermination	$700 million
6. Reimbursement for Special Education mandates	$1 billion
7. Reimbursement for cost of incarcerating undocumented immigrants	$879.7 million
8. Expanded federal funding for Foster Care	$86.9 million
TOTAL	**$6.9 billion**

Subcommittee Staff Comment and Recommendation. First, President Obama signed the Patient Protection and Affordable Care Act (H.R. 3590) on Tuesday, March 23, 2010. Effective upon this date of enactment, States are required to maintain Medicaid (Medi-Cal) eligibility standards, methodologies, and procedures until a Health Insurance Exchange is operational in the State, with minor exceptions. Therefore, the Governor's proposed trigger for Medi-Cal eligibility reduction would violate the MOE provisions.

Second, the proposal is broadly crafted and does not take into consideration the updated receipt of federal funds, such as for the Medicare Part D Clawback for federal ARRA received in February.

Third, many of the Medi-Cal Optional benefits proposed for elimination are "core" benefits which provide medically necessary assistance for individuals with chronic conditions. Elimination would likely result in increased hospitalization, such as with Diabetes, significant concerns with mobility and employment, such as not having access to wheelchairs and Prosthetics. Common sense needs to be applied.

It is recommended to reject the proposed trigger at this time.

Questions. The Subcommittee has requested the DHCS to respond to the following questions.

1. DHCS, Please provide an overview of the proposed trigger regarding Medi-Cal eligibility. How does the federal H.R. 3590, signed by President Obama, interact with the trigger proposal on eligibility? (Please be specific).
2. DHCS, Please provide a brief description of the Optional benefit proposal.

3. Governor's Proposal to Obtain Federal Approval to Establish Limits on Benefits, Expand Cost Sharing & Other Medi-Cal Program Changes

Budget Issue. The Governor proposes trailer bill legislation for the DHCS to negotiate with the federal government to implement various changes to Medi-Cal for a reduction of almost $2.4 billion ($750 million General Fund). No basis for the estimated savings has been provided to the Legislature.

This proposal is part of the Governor's request for "federal flexibility" and would require federal law changes and other federal approvals, including possible Waivers and State Plan Amendments (all requiring federal CMS approval).

The proposed trailer from the DHCS states that cost containment methods shall achieve a reduction of $750 million (General Fund) in 2010-11 and annually thereafter (i.e., ongoing reductions). It states that cost containment methods *may* include, but are *not limited to*, any or all of the following methods:

- Utilization controls, including limits on particular services.
- Increased cost-sharing for Medi-Cal enrollees through co-payments and premiums to the extent allowed by federal law.
- Adjustment to provider rates.

The DHCS would affect these changes based on federal approval. The Legislature would only receive notification of these changes through the Joint Legislative Budget Committee within 30-days prior to implementation.

Further, the proposed language provides the DHCS with the ability to implement these changes without taking *any* regulatory action, by means of an "All-County" letter or similar instruction.

The DHCS contends they have been meeting with both the federal CMS and constituency groups to discuss various cost containment proposals and that additional discussions need to occur before a more developed proposal can be provided to the Legislature for consideration at May Revision.

Background—Federal Law Restrictions on Cost-Sharing. Under federal law, States cannot impose premiums on Medi-Cal enrollees with incomes below the poverty level (100 percent) and can charge only nominal co-pays. For people with incomes between 100 percent and 150 percent of poverty, the State cannot charge premiums and can charge only limited co-pays (i.e., 10 percent of the cost of the service up to a maximum of 5 percent of the family's income). As such, for the vast majority of Medi-Cal consumers, the State cannot charge premiums.

Subcommittee Staff Comment. As noted by the CA Health and Human Services Agency in a January 2010 publication, California operates one of the *least costly* Medicaid programs in the nation. Our Medi-Cal Program utilizes extensive treatment authorization processes for the receipt of services and has some of the lowest Medi-Cal rates in the nation.

The Administration's draft trailer bill language provides sweeping authority to administer Medi-Cal without the involvement or oversight of the Legislature. Only a 30-day notification of changes would be provided to the Legislature with no real opportunity to have a public discourse or to know the human consequences of the changes. In short, the Governor seeks carte blanche authority to operate the Medi-Cal Program.

The affect of modifying the cost-sharing arrangements in Medi-Cal are disconcerting given the very low income level, and potentially could violate the maintenance of effort provisions of the Patient Protection and Affordable Care Act (H.R. 3590) if it affects Medi-Cal eligibility determinations. For example, it could be in violation if a Medi-Cal enrollee is required to pay a premium in order to continue enrollment.

This proposal was discussed by the Senate Budget Committee in its January 26 hearing during the Special Session deliberations and was not adopted. No additional information on the framework of this proposal has been provided.

The Administration states it will be providing more information at the May Revision.

Questions. The Subcommittee has requested the DHCS to respond to the following questions:

1. DHCS, Please provide an update on the Administration's thoughts as to what specific cost-containment is being considered.
2. DHCS, What interaction does this proposal have with the federal Patient Protection and Affordable Care Act (H.R. 3590) ?

4. Implementation of AB 1383—Hospital Quality Assurance Fee (QAF)

Budget Issues. AB 1383, Statutes of 2009, authorized the implementation of a Quality Assurance Fee (QAF) on General Acute Hospitals for the period of April 2009 through December 2010. Implementation of the QAF requires federal CMS approval which is pending.

The Governor's January budget proposes to appropriate these revenues within the Medi-Cal Program. There are *three* budget issues regarding implementation of the QAF.

First, the federal CMS is in the process of evaluating California's model for implementing the QAF. Presently, the DHCS assumes federal approval by May 1, 2010. The Subcommittee should obtain an update on these discussions and whether any substantial changes may need to be made to the QAF model in order to obtain federal approval.

Second, based on estimates as of January 2010, the DHCS anticipates the QAF to generate almost $3.6 billion in revenues across three fiscal years as shown in Table 1, below. The QAF will be deposited into the Hospital Quality Assurance Revenue Fund, where they are available for expenditure until January 1, 2013.

Table 1: Total Estimated Revenues from Hospital Quality Assurance Fees

Fiscal Year and Time Frame	Estimated Quality Assurance Fees (dollars in thousands)
2008-09 (April 2009 to June 2009) *****	$513,920
2009-10 (July 2009 to June 2010)	$2,055,680
2010-11 (July 2010 to December 2010)	$1,028,000
TOTAL Estimated Fees (April 2009 to December 2010)	$3,597,600

*****These funds will be reflected in the 2009-2010 state fiscal year.

Due to the timing of the federal CMS approval, the Subcommittee should obtain an update on the process and timing of the collection of the QAF from hospitals and if there are any concerns from constituency groups regarding implementation of the collection process.

Third, Table 2 below reflects total estimated payments, including federal funds (61.59 percent for ARRA where applicable), to be made by fiscal year as contained in the January budget for Medi-Cal, including State support for implementation

Table 2: Total Estimated Payments by Fiscal Year (as proposed by the DHCS)

AB 1383 Uses	2009-10 (April 2009-June 2010)	2010-11	Total Amount (7 Quarters)
1. Direct Grants to Public Hospitals	$387,500	$155,000	$542,500
2. Hospital Payments-- includes Private and Non-Designated Hospitals, Managed Care Plans and Mental Health Plans	$4,636,380	$1,854,550	$6,490,930
3. Children's Health (off-sets General Fund)		$560,000	$560,000
4. DHCS Staff & Administrative Request	$1,103	$1,335	$2,438
TOTAL Estimated Payments	**$5,024,983**	**$2,570,885**	**$7,595,868**

Each of the proposed expenditures from Table 2 is described below:

- **Direct State Grants to Public Hospitals**. As contained in statute, Public Hospitals are to receive direct grants in support of health care expenditures in an aggregate amount of $310 million (federal fiscal year). Public hospitals include both those operated by Counties and by the University of California system. These grants are *not* considered Medi-Cal payments and cannot be matched with federal funds. This is because these hospitals are now paid at the maximum amount that qualifies for federal matching funds under the existing Hospital Financing Waiver.

- **Hospital Payments.** This reference in Table 2 broadly covers several areas. First, private hospitals (those paying the fee) will receive *supplemental* Medi-Cal payments for inpatient and outpatient hospital and subacute care services. These supplemental payments are in addition to existing Medi-Cal per diem payments. Most of the payments will be made in this area.

  Second, the DHCS will increase Medi-Cal payment rates to Managed Care Plans (Plans) and require them to "pass-through" all of these funds to hospitals. The Plans will receive funds for those hospitals located in their service region as well as funds for hospitals in neighboring counties where there is no Medi-Cal Managed Care. The Plans will then pay *supplemental* payments to these hospitals as directed by the DHCS. The amount a hospital will receive will be based on the number of total Medi-Cal Managed Care days it provides.

  Third, the DHCS will provide payments to County Mental Health Plans to "pass-through" to hospitals providing Acute Psychiatric Services. This is a *supplemental* payment made in a similar manner as done with the Managed Care Plans.

  Fourth, non-designated hospitals (District Hospitals) will also receive *supplemental* Medi-Cal payments for inpatient services. Reimbursement rates for these hospitals are on a per diem basis and are lower than those for private hospitals since non-designated hospitals are not paying the QAF.

- **Children's Health.** The enabling legislation provided for $320 million annually for health care coverage of children. The $560 million represents seven quarters of QAF collection which corresponds to the statute. The $560 million serves as an offset to General Fund support in the Medi-Cal Program for providing services to children. These funds will be matched with federal funds. (Also see MRMIB, Healthy Families Program discussion.)

- **Department of Health Care Services—14 State Staff.** Utilizing an appropriation provided in the legislation, the DHCS has $1.1 million ($537,000 Private Hospital Supplemental Fund from the Hospital Finance Waiver and $566,000 federal funds) available in the current-year to commence with implementation. These funds are to support 3.5 State staff and to contract with two consulting firms (Covington and Burling, and Mercer) for their expertise with hospital financing issues.

For 2010-11, the DHCS requests a total of 14 State staff (two-year limited-term), and no contract funds, for an expenditure of $1.3 million ($463,000 Private Hospital Supplemental Fund, $163,000 Hospital Quality Assurance Revenue Fund, and $709,000 federal funds). The State staff includes the following positions:

(a) Staff Legal Counsel	two positions
(b) Associate Governmental Program Analysts	four positions
(c) Associate Management Auditors	three positions
(d) Associate and Trainee Accounting Analysts	four positions
(e) Office Support	one position

The DHCS states the workload for these staff includes the following key items:

- Participate in Medi-Cal Program changes (i.e., State Plan Amendments) that require negotiations with the federal CMS and resolve ongoing legal issues related to these changes;
- Collect data to develop total QAF amounts imposed on each hospital and to determine different types of payments to each hospital.
- Develop certification forms, fee notices, and prepare payment letters for hospitals.
- Develop a QAF collection database and prepare relevant collection processes and paperwork.
- Perform full-scope audits to reconcile the enhanced payments to Managed Care Plans.
- Calculate and certify the Managed Care payments as actuarially sound pursuant to federal regulations.
- Develop accounting procedures for processing new hospital payment invoices and implement a new federal claiming process.

Background—The Fee. The enabling legislation specifies a three-tier QAF structure which is intended to maximize the number of hospitals that benefit from it and minimize the number of hospitals that do not, while still meeting federal requirements. Certain categories of hospitals, such as designated public, small and rural, most specialty care and long-term care, are exempt from paying the fee.

The fees in statute are as follows:

- $27.25 for every inpatient day of patients enrolled in a Managed Care Plan, *excluding* Medi-Cal;
- $233.46 for every inpatient day of patients covered by Fee-for-Service, *excluding* Medi-Cal; and
- $293.00 for every inpatient day of patients *covered* by Medi-Cal, whether Managed Care or Fee-for-Service.

It should be noted the DHCS may alter the specified QAF amount slightly in order to obtain federal CMS approval. As such, the fee structure may be altered. Fees are to be computed

starting on the effective date of the bill and to continue through December 31, 2010 (i.e., corresponds to existing expiration date of the federal ARRA FMAP amount 61.59 percent).

Background—Use of Fees and Taxes. Taxes and fees assessed on health care providers have become a key component of Medicaid financing in 43 of 50 States. In addition to hospitals, California currently applies provider fees on certain Nursing Facilities and Intermediate Care Facilities for the Developmentally Disabled (ICF-DD), and has also extended an existing State gross premium tax on insurance to Medi-Cal Managed Care Plans (AB 1422, Statutes of 2009). These revenues, coupled with federal matching funds (including enhanced ARRA funds), have been used to increase Medi-Cal reimbursement to providers, to finance quality improvement efforts, and to maintain or expand health care coverage. Federal law restricts the use of provider taxes and fees, and all Medicaid applications require federal CMS approval.

Subcommittee Comment. The DHCS must obtain *federal CMS approval* for several aspects of QAF implementation, including:

- An amendment to the existing Hospital Financing Waiver for the QAF to be applied to participating hospitals;
- The overall QAF fee design and model;
- Distribution of the payments to hospitals; and
- Method of payment to be made to Medi-Cal Managed Care Plans and County Mental Health Plans for the pass-through to hospitals.

It is important to obtain an update from the DHCS to ensure transparency, and to enable the Legislature to work collaboratively with the Administration to secure federal CMS assistance and approval.

Questions. The Subcommittee has requested the DHCS to respond to the following questions:

1. DHCS, Please provide a brief overview of the structure for this Quality Assurance Fee (QAF). and its update regarding progress being made with the federal CMS.
2. DHCS, Please provide an update regarding progress being made with the federal CMS on its approval.

5. Proposed 10 Percent Reduction to Public Hospitals for 2010-11

Budget Issue. The DHCS proposes trailer bill language to *shift* a total of $54.2 million in federal funds from the Safety Net Care Pool, designated for uncompensated care for Public Hospitals and the Los Angeles Medical Services Preservation Fund (L.A. Preservation Fund), to backfill for General Fund support in certain state-operated programs.

The trailer bill language provides that the reduction shall occur for hospital services provided during the period of July 1, 2010 through June 30, 2011. As such, this reduction would be applied under the new, presently being crafted 1115 Medi-Cal Waiver.

Of the $54.2 million shift, almost $30 million would be used for backfill of General Fund support in 2010-11 and the remaining amount of $24.2 million would be expended in 2011-12. The DHCS states this is due to the lag between the date of the service and the date that expenditures are paid.

AB 3X 5, Statues of 2009 (trailer bill), redirected $54.2 million, or 10 percent, as referenced for 2009-2010 (as applied to the existing Hospital Financing Waiver). Therefore the DHCS contends they need to continue this redirection for at least one more year.

The Tables below summarize both fiscal years, along with the existing baseline assumptions

Table 1: Total Redirection for 2009-2010

State Program (Dollars in Thousands)	Existing Redirection (Baseline)	AB 3X 5 Amount (Increase)	Total Amount of Shift for 2009-10
Medically Indigent--LTC	$19,464	$5,100	$24,564
Breast & Cervical Cancer	1,000	--	$1,000
CA Children's Services Program	22,000	32,157	$54,157
Genetically Handicapped Persons	18,000	16,943	$34,943
TOTALS	**$60,464**	**$54,200**	**$114,664**

Table 2: Total Redirection for 2010-2011

State Program	Existing Redirection (Baseline)	Additional Shift for 2010-11 (Increase)	Total Amount of Shift for 2010-11
Medically Indigent--LTC	$8,725	$2,500	$11,225
Breast & Cervical Cancer	$500	--	500
CA Children's Services Program	$22,000	$17,000	39,000
Genetically Handicapped Persons	$18,000	$10,000	28,000
TOTALS (with $24.2 million for 2011-12)	**$49,225**	**$29,500**	**$78,725**

Background—Summary of Existing Hospital Financing Waiver. As a result of federal policy changes, California was required to completely change its method in which Safety-Net Hospitals (about 146 hospitals) are financed under the Medi-Cal Program. The Administration negotiated a five-year federal Waiver with the federal CMS which was completed as of September 1, 2005 and expires as of *August 30, 2010*. This Waiver is to provide over $2 billion in annual reimbursement to hospitals.

The federal requirements for this Hospital Finance Waiver are contained in the *"Special Terms and Conditions"* document which serves as a contract between California and the federal CMS. Senate Bill 1100 (Perata and Ducheny), Statutes of 2005, provides the state statutory framework for implementing it.

Under this Waiver, Public Hospitals certify their health care expenditures (referred to as "Certified Public Expenditures" or CPE) in order to obtain federal funds, and Private Hospitals solely on the state's General Fund to obtain their federal funds. In addition, Public Hospitals use Intergovernmental Transfers (IGT's) on a limited basis to obtain federal matching funds.

The framework of the Waiver is quite complex and consists of several funding mechanisms, including the Health Care Support Fund (i.e., Safety Net Care Pool), Stabilization Funding, Disproportionate Share Hospital (DSH) payments, replacement DSH and replacement Graduate Medical Education payments, Physician Services, Distress Hospital Fund, and Medi-Cal per diem and cost-based payments.

Background—Pending Comprehensive 1115 Medi-Cal Waiver. With the existing Hospital Financing Waiver scheduled to sunset as of August 2010, trailer bill legislation-- AB 4X 6, Statutes of 2009—was adopted to commence with the framework for a new, more comprehensive Waiver for California. The goals of this new Waiver are:

- Strengthening California's health care safety net;
- Reducing the number of uninsured individuals;
- Optimizing opportunities to increase federal financial participation;
- promoting long-term, efficient and effective use of State and local funds;
- Improving health care quality and outcomes; and
- Promoting home and community-based care.

The statute also directs for the Waiver to provide Medi-Cal enrollees with access to better coordinated and integrated care to improve outcomes and help slow the long-term growth in program costs. Among other things, it provides for the more comprehensive enrollment of individuals into specified organized delivery systems, such as managed care, enhanced primary care case management, or a medical home model.

The DHCS has developed a concept paper for the Waiver and is convening extensive workgroups to engage diverse stakeholders in crafting a framework for this Waiver. Considerable work needs to be done over the next several months, including the development of an implementation plan. This plan is to be provided to the fiscal and policy

committees of the Legislature prior to implementation of the Waiver, and at least 60-days prior to an appropriation by the Legislature for this purpose.

Constituency Letters. The Subcommittee is in receipt of numerous letters, including from the CA Hospital Association of Disproportionate Share Hospital Task Force, in strong opposition to the Governor's additional redirection of federal Safety Net Care Pool Funds.

Subcommittee Staff Comment and Recommendation. With the ongoing fiscal crisis clearly there is a need to obtain General Fund relief to maintain core health care treatment programs, such as the California Children's Services, Medically Indigent Long-Term Care, Breast and Cervical Cancer Treatment, and Genetically Handicapped Persons (mainly hemophilia treatment services).

However, it is unclear at this time how the overall structure of the 1115 Waiver is to be crafted, particularly the complexities of the financing. The use of certified public expenditures (CPE's) and other funding sources besides General Fund support should be further clarified prior to adoption of this proposal. Additional transparency would be helpful.

The effect of the Governor's proposal on Public Hospitals and hospitals receiving funds from the L.A. Preservation Fund is that fewer federal funds would be available for uncompensated care provided to medically needy individuals.

It is recommended to keep this issue "open", pending receipt of the May Revision.

Questions. The Subcommittee has requested the DHCS to respond to the following questions:

1. DHCS, Please describe the budget proposal.

6. Proposed 10 Percent Reduction to Private Hospitals for 2010-11

Budget Issue. The Governor also proposes to reduce by 10 percent, or $52 million, the amount Private Hospitals and District Hospitals receive through the Waiver by making adjustments to certain disproportionate share hospital payments, including replacement payments. This issue corresponds to the 10 percent Public Hospital reduction, above.

The trailer bill language provides that the reduction shall occur for hospital services provided during the period of July 1, 2010 through June 30, 2011. As such, this reduction would be applied under the new, presently being crafted 1115 Medi-Cal Waiver.

AB 4X 5, Statutes of 2009 (trailer bill), redirected $52 million (Disproportionate Share Hospital Replacement Fund) to offset General Fund support in the Medi-Cal Program for 2009-2010.

Under the state's Hospital Financing Waiver, hospitals participating in the Medi-Cal Program receive funds from several sources based on a complex formula. A key aspect of this arrangement is that Public Hospitals receive federal funds based on the use of their certified public expenditures and intergovernmental transfers, whereas Private Hospitals and District Hospitals receive a mixture of state General Fund support and federal funds.

The payments the DHCS is proposing to reduce are "replacement" Disproportionate Share and "replacement" Graduate Medical Expenses. When the Waiver was structured, federal funds which the Private and District Hospitals had received were restructured with the intent of the state to ensure that in the aggregate, these hospitals would receive payments equal to what they received in 2004-05 (i.e., prior to the Hospital Financing Waiver).

Constituency Letters. The Subcommittee is in receipt of numerous letters, including from the CA Hospital Association of Disproportionate Share Hospital Task Force, in strong opposition to the Governor's additional redirection of federal Safety Net Care Pool Funds.

Subcommittee Staff Comment. The DHCS proposal would affect the distribution of funds within the upcoming 1115 Medi-Cal Waiver. Therefore, it is recommended to keep this issue "open", pending receipt of the May Revision.

Questions. The Subcommittee has requested the DHCS to respond to the following questions:

1. DHCS, Please describe the budget proposal.

7. Implementation of Medi-Cal Managed Care Tax (AB 1422, Statutes of 2009)

Budget Issues. Among other things, AB 1422, Statutes of 2009, extended the State's existing 2.35 percent gross premium tax on insurance (all types) to Medi-Cal Managed Care Plans. This tax is effective retroactively from January 1, 2009 through to December 31, 2010.

Revenues from this tax are matched with federal funds and will be used for the following:

- Provide a reimbursement rate increase to Medi-Cal Managed Care Plans;
- Provide a reimbursement rate increase to health plans participating in the Healthy Families Program; and
- Fund health care coverage for children in the Healthy Families Program (serves as a backfill to the General Fund). (Discussion under the Managed Risk Medical Insurance Board item.)

Specifically, the enabling legislation requires the State to allocate 38.41 percent of the tax revenue to the DHCS to provide enhanced rates to Medi-Cal Managed Care Plans. The remaining 61.59 percent of the tax revenues to the Managed Risk Medical Insurance Board for essential preventive and primary health care services through the Healthy Families Program.

With respect to Medi-Cal Program impacts, there are *two* key budget issues, including changes to the Medi-Cal Managed Care capitation rates, and the DHCS' trailer bill proposal to extend the sunset date of the tax to June 30, 2011.

With respect to Medi-Cal Managed Care capitation rates, the DHCS needs to adjust the current-year to reflect the tax retroactive date of January 1, 2009, *and* also needs to provide for 2010-11. According to the DHCS, a total of $239.2 million (total funds) is available for this purpose for 2009-10 and a total of $162.6 million (total funds) is available for 2010-11.

The Medi-Cal Managed Care Plans affected by the tax include: (1) Two Plan Model (Local Initiatives); (2) County Organized Health Systems (COHS); (3) Geographic Managed Care; (4) AIDS Healthcare; and (5) SCAN.

The DHCS is also proposing trailer bill language to: (1) extend the existing sunset from December 31, 2020 to July 1, 2011; and (2) amend the applicable percentages for reimbursement to the DHCS due to the sunset of the federal ARRA. The proposed six-month extension would provide an additional $82 million in revenues, and a corresponding $63 million in additional federal funds.

Background—Medi-Cal Managed Care QIF and Federal Changes. In 2005, a "Quality Improvement Fee" (QIF) for Medi-Cal Managed Care organizations was implemented. The fee was 5.5 percent of the total operation revenue of each organization, except for four county organized healthcare systems (COHS) who were federally exempt from payment.

Initially, about 75 percent of the revenues collected from the QIF was matched with federal funds and used for payments to the Medi-Cal Managed Care organizations. The remaining 25 percent was retained to backfill for General Fund support in the Medi-Cal Program.

Effective October 1, 2007, with implementation of the DHCS' new Medi-Cal Managed Care rate methodology, only 50 percent of the revenues from QIF was used to match federal funds and used for payments to these organizations. The remaining 50 percent was retained to backfill for General Fund support in the Medi-Cal Program. Therefore, while the amount these organizations pay is returned to them, they realized no *net* benefit.

Due to federal law changes, States had until October 1, 2009 to modify these fee structures which required application of provider fees or taxes to be more broadly applied (i.e., to include health maintenance organizations and preferred provider organizations). As such, this QIF sunset as of September 30, 2009 and AB 1422, Statutes of 2009 *generally* serves as its replacement.

Subcommittee Staff Comment and Recommendation. The May Revision should provide more clarity regarding the revenues to be generated from implementation of AB 1422, as well as the status of the federal ARRA extension. Therefore it is recommended to adopt the Administration trailer bill language as "placeholder" and to keep issues related to Medi-Cal Managed Care rates "open".

Questions. The Subcommittee has requested the DHCS to respond to the following questions:

1. DHCS, Please provide an update regarding the current-year rate adjustments for Medi-Cal Managed Care Plans due to the gross premium tax revenues. Are there any concerns from the Plans regarding these adjustments?
2. DHCS, Please provide a brief summary of the trailer bill proposal.

8. Newly Qualified Legal Immigrant Adults

Budget Issue. The Governor proposed legislation in Special Session to eliminate full-scope Medi-Cal for newly qualified legal immigrant adults in the U.S. for less than five years for a net reduction of $433,000 (total funds) for 2009-10, and a reduction of $33.4 million (decrease of $53.8 million General Fund and increase of $20.4 million federal funds). This proposal was *not* adopted in the Special Session.

Under this DHCS proposal, 48,600 adults would only be eligible to receive emergency services, prenatal care, state-only breast and cervical treatment, long-term care, and tuberculosis services. Other preventive care, medications for chronic conditions, and related full-scope services would not be reimbursed under Medi-Cal.

Due to federal law changes enacted in 1996, federal matching funds are not provided for non-emergency services for this category of individual. Federal law does require states to provide emergency services and will reimburse for these services if they are identified as being an emergency medical service (according to the attending medical staff).

The DHCS states under their proposal to eliminate full-scope services to these individuals, 56 percent of the cost for services would shift to emergency services and would be partially reimbursed by the federal government.

Subcommittee Staff Comment and Recommendation. California has *always* provided legal immigrant adults with full-scope services in Medi-Cal if they otherwise meet all other eligibility requirements (such as income and residency). Medi-Cal uses 100 percent General Fund support for this purpose, but the State is reimbursed by the federal government for those services identified as being an emergency service.

Enactment of the DHCS proposal would most likely (1) impair people's health, particularly individual's with chronic conditions; (2) result in increased use of hospital emergency rooms; (3) result in increased uncompensated care costs for hospitals and clinics; and (4) shift some costs to County indigent health care programs.

California has incorporated the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) option to obtain federal funds for legal immigrant children and pregnant women by eliminating the previous five-year waiting period. As such, federal funds are now obtained for this population.

It is recommended to leave this issue open until the May Revision.

Questions. The Subcommittee has requested the DHCS to respond to the following questions.

1. DHCS, Please describe the proposal.
2. DHCS, Does your proposal violate the maintenance of effort (MOE) provisions of the federal ARRA, including potential cost-shifting to local governments, or the Patient Protection and Affordable Care Act (H.R. 3590)? If not, why not please?

9. Governor's Proposal: Persons Permanently Residing Under Color of Law (PRUCOL)

Budget Issue. The Governor proposed legislation in Special Session to eliminate full-scope Medi-Cal for individuals designated as PRUCOL for a net reduction of $289,000 (reduction of $465,000 General Fund) in 2009-2010, and $39.6 million (reduction of $63.8 million General Fund) in 2010-11. This proposal was *not* adopted in the Special Session.

Under this DHCS proposal, 17,000 people would only receive emergency services, prenatal care, state-only breast and cervical cancer treatment, long-term care, and tuberculosis services. Other preventive care, medications for chronic conditions, and related full-scope services would not be reimbursed under Medi-Cal.

Due to federal law changes enacted in 1996, federal matching funds are not provided for non-emergency services for this category of individual. Federal law does require states to provide emergency services and will reimburse for these services if they are identified as being an emergency medical service (according to the attending medical staff).

The DHCS states under their proposal to eliminate full-scope services to these individuals, 56 percent of the cost for services would shift to emergency services and would be partially reimbursed by the federal government.

PRUCOL generally means that the immigration authorities are aware of a person's presence and have no plans to deport or remove them from the county. Medi-Cal lists several immigrant statuses that are considered PRUCOL. The various PRUCOL categories are permitted by the Department of Homeland Security to remain in the U.S.

Subcommittee Staff Comment and Recommendation. California has *always* provided full-scope services to these individuals if they otherwise meet all other eligibility requirements.

Enactment of the DHCS proposal would most likely (1) impair people's health, particularly individual's with chronic conditions; (2) result in increased use of hospital emergency rooms; (3) result in increased uncompensated care costs for hospitals and clinics; and (4) shift some costs to County indigent health care programs.

It is recommended to leave this issue open until the May Revision.

Questions. The Subcommittee has requested the DHCS to respond to the following questions.

1. DHCS, Please describe the proposal.
2. DHCS, Does your proposal violate the maintenance of effort (MOE) provisions of the federal ARRA, including potential cost-shifting to local governments, or the Patient Protection and Affordable Care Act (H.R. 3590)? If not, why not please?

10. DHCS Proposal to Implement Mid-Year Status Reporting for 6 Months

Budget Issue. The DHCS proposes a reduction of $4.9 million ($2.5 million General Fund) by rolling back the annual eligibility for Children from 12-months to 6-months as of January 1, 2011. They state if the federal ARRA is extended to June 30, 2011, then this mid-year roll back will *not* occur. Yet the Governor's budget assumes extension of the federal ARRA to June 30, 2011. Therefore, the budget is clearly in conflict.

Background—Existing State Law. Inclusion of children as part of the semi-annual reporting process (every 6-months) was enacted in Assembly Bill 1183, Statutes of 2008 (Omnibus Health Trailer Bill), and became effective as of January 1, 2009. Previously, only annual reporting was required for Children.

The enactment of the federal ARRA in February 2009 provided States with enhanced FMAP for 27 months (October 1, 2008 through December 2010) but a "maintenance of effort" was required. One of the key federal requirements is that states may not have eligibility standards, methodologies or procedures in place that are more restrictive than those in effect as of July 1, 2008. Any state that implemented more restrictive policies since July 1, 2008, had until July 1, 2009, to rescind them. The state would then be *fully* eligible for the enhanced match, retroactive to October 1, 2008.

Adoption of SB 3X 24 (Alquist), Statutes of 2009, among other things, restored annual reporting for Children until the enhanced ARRA federal funds are no longer available. About $10.1 billion (federal funds) was at risk if California did not comply.

Subcommittee Staff Comment and Recommendation. First, President Obama signed the Patient Protection and Affordable Care Act (H.R. 3590) on Tuesday, March 23, 2010. Effective upon this date of enactment, States are required to maintain Medicaid (Medi-Cal) eligibility standards, methodologies, and procedures until a Health Insurance Exchange is operational in the State, with minor exceptions. Therefore, this DHCS proposal would violate these MOE provisions.

Further, independent analyses have shown that annual reporting for Children is cost-beneficial because it assists in assuring uninterrupted health care coverage and provides a medical home for comprehensive coverage (most children are enrolled in Managed Care). Further, it serves to focus limited state dollars on direct health care services versus administrative paperwork and shifting between programs.

It is recommended to reject this proposal and to adopt trailer bill language to restore annual eligibility for children.

Questions. The Subcommittee has requested the DHCS to respond to the following questions.

1. DHCS, Please describe the budget proposal and comment on whether it is in violation.

11. Proposed Changes to Special Needs Trust Recovery

Budget Issue. The DHCS is proposing trailer bill language to amend Section 3605 of the Probate Code and Section 14009.5 of Welfare and Institutions Code to change existing statute and case law (Shewry v. Arnold, from 2004; and Dalzin v. Belshe, from 1997) relating to Special Needs Trust recovery.

The budget assumes savings of $3.6 million ($1.8 million General Fund) through the enactment of the proposed trailer bill language. This savings level is based upon a DHCS estimate of recovery potential from these trusts and recoupment for Medi-Cal expenses.

Subcommittee Staff Comment and Recommendation-- Reject. The Administration has proposed similar changes to statute for the recovery of funds for Medi-Cal expenses from Special Needs Trusts. Most recently a similar proposal was rejected without prejudice by the Joint Budget Conference Committee in 2009. Due to the complexities of both federal and state law, it was recommended for the Administration to proceed with policy legislation.

The DHCS is seeking to substantially change the dynamics of recovery from Special Needs Trusts and should therefore be proceeding with policy legislation so a full discourse can be had with the appropriate policy committees (including both Judiciary and Health). For example, a provision of the DHCS language states:

> "These claims shall *not* be governed by *any* provision of State for federal law pertaining to estate recovery. To the extent that Shewry v. Arnold (2004) 125 Cal.App4th 186 is inconsistent with the provisions of this section, it is expressly superseded."

Such sweeping language is not appropriate for budget trailer bill.

Questions. The Subcommittee has requested the DHCS to respond to the following questions.

1. DHCS, Please describe the trailer bill language and budget proposal.

II. Managed Risk Medical Insurance Board (MRMIB)

A. OVERALL BACKGROUND

Purpose and Description of Department. The Managed Risk Medical Insurance Board (MRMIB) administers programs, which provide health care coverage through private health plans to certain groups without health insurance. The MRMIB administers the: **(1)** Healthy Families Program; **(2)** Access for Infants and Mothers (AIM) Program; and **(3)** Major Risk Medical Insurance Program (MRMIP).

Summary of Budget Appropriation. The budget proposes total expenditures of almost $1.1 billion ($128.4 million General Fund) for all programs administered by the Managed Risk Medical Insurance Board for 2010-11 as shown in the chart below.

Summary of Expenditures (dollars in thousands)	**2009-10**	**2010-11**	**$ Change**
Program Source			
Major Risk Medical Insurance Program (including state support)	$65,127	$36,953	-$28,174
Access for Infants & Mother (with state support)	$77,448	$122,195	$44,747
Healthy Families Program (with state support)	$1,142,384	$928,821	-$213,563
County Health Initiative Program	$1,710	$1,789	$79
Totals Expenditures	**$1,286,669**	**$1,089,758**	**-$196,911**
General Fund	$216,983	$128,376	-$88,607
Federal Funds	$779,667	$666,867	-$112,800
Other Funds	290,019	$294,515	$4,496

(Discussion items for the Healthy Families Program begin in the next page.)

1. Governor's Proposal to Reduce Eligibility in HFP from 250 to 200 Percent

Budget Issue. The Governor proposes legislation to reduce eligibility in the Healthy Families Program (HFP) from 250 percent to 200 percent of poverty for a reduction of $41.9 million ($10.5 million General Fund) in 2009-2010, and $252.4 million ($63.9 million General Fund) in 2010-11.

Under the Governor's proposal, 203,310 children would be dropped from coverage as of May 1, 2010, and an estimated 5,670 children each month (21 percent of new enrollment) would be denied HFP enrollment thereafter. For 2010-11, MRMIB states that at least 206,368 children would be denied enrolled under this proposal.

About 875,000 children are currently enrolled in the HFP (as of March 1, 2010).

The Governor's proposal was part of the Special Session as discussed in the Senate Budget & Fiscal Review Committee hearing of January 26, 2010; it was *not* included as part of the Legislature's package.

Background—Description of Healthy Families Program. The HFP provides subsidized health, dental and vision coverage through managed care arrangements for children (up to age 19) in families with incomes up to 250 percent of the federal poverty level, who are *not* eligible for Medi-Cal but meet citizenship or immigration requirements. The benefit package is modeled after that offered to state employees. Eligibility is conducted on an annual basis.

A 65 percent federal match is obtained through a federal allotment (Title XXI funds). The HFP is *not* an entitlement program. The MRMIB Board has authority to established waiting lists if necessary.

In addition, infants born to mothers enrolled in the Access for Infants and Mothers (AIM) Program (200 percent of poverty to 300 percent of poverty) are immediately enrolled into the Healthy Families Program and can remain under the HFP until at least the age of two. If these AIM to HFP two-year olds are in families that exceed the 250 percent federal income level, then they are no longer eligible to remain in the HFP.

Table #2: Background Summary of Existing Eligibility for the Healthy Families Program

Type of Enrollee in the HFP	Income Level	Comments
Infants up to the age of two years who are born to women enrolled in Access for Infants & Mothers.	200 % to 300 %	• Income from 200% to 250%, covered through age 18. • Income is above 250%, they are covered up to age 2.
Children ages one through 5 years	133 % to 250 %	Healthy Families Program covers from 133 percent and above because children below this are eligible for Medi-Cal.
Children ages 6 through 18 years	100 % to 250 %	Healthy Families Program covers children in families above 100%. Families with two children may be "split" between programs due to age.
Children enrolled in County "Healthy Kids" programs include children without residency documentation; and children from 250% to 300%.	Not eligible for HFP, including 250% to 300%.	State provides federal S-CHIP funds to county projects as approved by the MRMIB. Counties provide the match for the federal funds.

Background—HFP Benefit Package. The HFP benefit package is modeled after that offered to state employees, including health, dental and vision. The enabling federal legislation—the State's Children's Health Insurance Program (S-CHIP)—required states to use this "benchmark" approach. These benefits are provided through managed care arrangements. The HFP directly contracts with participating health, dental and vision care plans. Participation from these plans varies across the state but consumer choice has *historically* always been available.

In addition to these HFP benefits, enrolled children can also access the California Children's Services (CCS) Program if they have a CCS-eligible medical condition. An HFP enrolled child is also eligible to receive *supplemental* mental health services provided through County Mental Health Plans. These additional services are provided in accordance with state statute that created California's Healthy Families Program (i.e., California's S-CHIP). These services are also available to children enrolled in Medi-Cal.

Summary of Past Cost Containment and Fund Shifts. A series of cost-containment actions and fund shifts have been implemented for the HFP over the past two-years. Key changes have included the following:

- **Provider Rates.** Reduced by 5 percent the rates paid to health, dental and vision plans in 2008. This reduction is ongoing.
- **Premiums.** The monthly premiums paid by families for their children's enrollment have been increased in 2005, and twice in 2009. This is discussed in more detail in the next Agenda item, below.
- **Dental Services.** Adopted an annual limit of $1,500 for dental coverage, effective as of November 1, 2008.
- **Copayments for Certain Services.** As of November 2009, copayments were increased for families with incomes from 150 percent to 250 percent as follows:
    - Non-preventive health, dental, and vision services—from $5 to $10.
    - Generic prescription drugs—from $5 to $10.
    - Brand name prescription drugs—from $5 to $15, unless no generic is available or brand name drug is medically necessary.
    - Emergency room visits—from $5 to $15, unless the child is admitted to hospital.
- **Additional Federal Funds—CHIPRA.** The federal Children's Health Insurance Program Reauthorization Act (CHIRPA) of 2009, signed by President Barack Obama, gave States the option of providing coverage for legal immigrant children with less than 5-years in the U.S. and provided 65 percent federal matching funds for this purpose. California had been providing this coverage with 100 percent General Fund support. As such, this federal action saves California about $12 million annually.

- **Obtained Alternative Funding.** First, AB 1422, Statutes of 2009, extended the gross premium tax to Medi-Cal Managed Care organizations (MCO) as previously referenced. Of the amount collected 61.59 percent is to be provided to the HFP. The MRMIB states it is assumed that $239 million will be backfilled by these revenues, assuming an extension of the tax to June 30, 2011 and an extension of the federal ARRA (to June).

  Second, through continued discussions with the CA Families First Commission (First Five), a total of $77.2 million (Proposition 10 Funds) are committed for 2009-2010, and $55.6 million (Proposition 10 Funds) is proposed for 2010-11. According to MRMIB figures, the Proposition 10 Funds for 2010-11 would be $24.4 million more but were adjusted downward due to the Governor's proposal to eliminate children in the 201 percent to 250 percent of poverty category.

  In total, these two alternative funding sources will save *at least* $371.8 million in General Fund support across the two-years.

Subcommittee Staff Comment and Recommendation. First, the historic Patient Protection and Affordable Care Act, H.R. 3590, signed by President Obama requires States to retain current income eligibility levels for children in Children's Health Insurance Programs (Healthy Families in California) that were in place as of June 16, 2009. Therefore, the Governor's reduction would violate the MOE provisions.

Second, a lack of health care coverage results in episodic care, increased emergency room visits and likely absences from school. The cost-benefit of proving health care to children is well documented. Healthy children are more likely to be good students, and to have healthy adult outcomes, including employment.

Third, the HFP receives a 65 percent federal match, utilizes two sources of alternative funding, and requires families to pay premiums and copayments for their children's coverage. Many adjustments have been enacted already to contain, reduce and shift costs due to the economic recession.

Fourth, the Governor's "trigger" for receipt of federal funds had also proposed to eliminate the Healthy Families Program. This issue becomes moot as well due to the federal law as noted.

Questions. The Subcommittee has requested the Managed Risk Medical Insurance Board to respond to the following questions:

1. MRMIB, Please provide a brief summary of the key actions taken to-date to contain costs within Healthy Families, including the cost-sharing adjustments and use of alternative funds.
2. MRMIB, Please provide a brief explanation of the Governor's proposal to eliminate children with family incomes from 201 to 250 percent of poverty from enrollment in HFP.
3. MRMIB, Is it your understanding that the Governor's proposal to reduce eligibility would violate the MOE provisions as noted?

2. Eliminate Vision Benefit & Increase Premiums Paid by Families

Budget Issues. The Governor proposes legislation to (1) eliminate vision coverage, and (2) increase monthly premiums for families with incomes from 151 percent to 200 percent of poverty effective July 1, 2010. A reduction of $18.1 million ($8.9 million General Fund) is reflected for the vision coverage elimination, and $38.7 million ($12.8 million General Fund) for the premium increase, for a total reduction of $65.8 million ($21.7 million General Fund).

An elimination of vision coverage results in 900,000 children no longer having access to eye exams and glasses. According to the MRMIB, only medically necessary vision-related services, such as eye surgery and treatment for eye injuries, would be covered.

Monthly premiums for families from 151 percent to 200 percent of poverty would be increased by $14 per child, or by 87 percent, for a total of $30 per child per month, with a family maximum of $90 for three or more children.

It should be noted that premiums for this income category have been increased twice in less than one year. First, as of February 1, 2009, premiums were increased from $9 per child per month to $12 per child per month (i.e., $3 more per month). The family maximum was correspondingly increased from $27 to $36 per month. Second, as of November 1, 2009, they were increased yet again.

The Table below provides a summary of the recent premium changes under the HFP and the affect of this proposal.

Governor's Healthy Families Program—Proposed Premium Increases

HFP Subscriber Family Income %	Monthly Premium (February 1, 2009)	Existing Premium (November 1, 2009)	Governor's 2010-11 Proposal
100 to 150 %	$7 per child Maximum of $14	No Change (federal law prohibits)	No Change (federal law prohibits)
151 to 200 %	$12 per child Maximum of $36	$16 per child Maximum of $48	$30 per child Maximum of $90
201 to 250 %	$17 per child Maximum of $51	$24 per child Maximum of $72	Eliminates Eligibility

Background—Discounts Offered for HFP Subscribers. HFP does offer subscribers "premium discount options" to offset some costs associated with premiums and co-payments. Discounts offered include (1) $3 per child per month discount for enrollment in a "community provider plan"; (2) subscriber paying 3 months in advance to get one month "free"; and (3) a 25 percent monthly discount for payment of premiums through electronic funds transfer.

Further, HFP subscribers can choose a community provider health plan, in most regions of the State, which have lower-cost monthly premiums.

Background—Federal Law Limits Cost-Sharing Amounts Charged. Federal law imposes limits on the total aggregate amount of all cost-sharing, including premiums and co-payments, at a maximum of 5 percent of family income on a monthly basis.

It should also be noted that federal law does not allow for cost-sharing for higher-income families to be less than that imposed on lower-income families. Therefore, if premiums are increased for children in the 151 percent to 200 percent income level, they would have to be less than that paid by families with incomes above 201 percent of poverty, unless this higher income level was also increased.

Further, according to the MRMIB, the federal CMS has previously expressed concerns that the higher the cost-sharing imposed on families becomes (close to the 5 percent threshold), the more likely the federal CMS will be to require the MRMIB and participating Health Plans to more directly track and monitor individual family out-of-pocket expenses. This could become a closely enterprise for the State and for participating Health Plans, if ever required.

Subcommittee Staff Comment. As previously noted, considerable cost containment and alternative funding sources have been identified to save a considerable amount of General Fund support. Elimination of the vision benefit for 900,000 children would only result in children not receiving appropriate health care and potentially having difficulty at school for not being able to see clearly.

Increasing premiums also poses a problem since most HFP families have incurred two premium increases, as well as a co-payment increase, within one year. Concerns with approaching the five percent federal law restriction is also evident.

The HFP will have May Revision adjustments on the natural and it is recommended to keep this issue "open" pending its receipt.

Questions. The Subcommittee has requested the Managed Risk Medical Insurance Board to respond to the following questions:

1. MRMIB, Please provide a summary of the proposal to eliminate the Healthy Families vision benefit, as well as the proposed increase to premiums.